January 26, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P

Re: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Summary

The National Association of Insurance and Financial Advisors (NAIFA) appreciates the opportunity to comment on proposed rule ***CMS-4212-P***, ***Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program***.

Founded in 1890, NAIFA is the leading association for financial service professionals in the United States. NAIFA members subscribe to a strong Code of Ethics and represent a full spectrum of practice specialties to promote financial security for all Americans, including Medicare beneficiaries who must regularly navigate the complexities of the health insurance market. Complimented by its professional development and consumer communities, the Society of Financial Service Professionals and Life Happens, NAIFA delivers value through advocacy, service, and education.

The Medicare landscape is changing rapidly, making it more important than ever that beneficiaries have access to professional, qualified agents that ensure they are making the best choices that fit their healthcare needs. To better support the millions of Medicare beneficiaries and the agents that serve them, NAIFA has partnered with several leading Field Marketing Organizations to form a Medicare Collective that supports policies protecting access to trusted guidance and improving beneficiary outcomes.

NAIFA applauds CMS for many of the provisions in the proposed rule, particularly the proposed changes concerning third-party marketing organizations (TPMOs), scope of appointment parameters, call recording retention requirements, special enrollment periods for provider terminations, and unnecessary restrictions currently in place for educational and marketing

events. These are thoughtful, fair, and balanced revisions that will benefit Medicare beneficiaries and the agents that work with them every day.

Where applicable, we would like to offer specific recommendations and additional comments regarding the proposed changes that could further enhance beneficiary protection, regulatory efficiency, and marketplace stability.

I. Modifying the Definition of Third-Party Marketing Organizations (TPMOs)

NAIFA strongly supports CMS's proposal to modify the current definition of a third-party marketing organization (TPMO) under § 422.2260 and § 423.2260 to clearly specify the roles of TPMOs and the requirements applicable to them. This clarification is long overdue and will benefit beneficiaries, plans, and the agents who dutifully serve Medicare beneficiaries.

The current regulatory definition defines TPMOs broadly as "organizations and individuals, including independent agents, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR."

This definition encompasses a wide range of entities with vastly different business models, compliance capabilities, and relationships with Medicare plans, which creates confusion in the marketplace and makes it extremely difficult to apply appropriate, consistent regulatory standards based on the different roles of such entities within the Medicare ecosystem. We appreciate CMS's desire for differentiation as all TPMOs are currently treated as a single category despite significant differences among them, as discussed in greater detail below.

These entities play a different role in the "chain of enrollment" and have different compliance capabilities, thus presenting different oversight considerations. Applying uniform requirements across such diverse entities has created ongoing regulatory inefficiencies and, in some cases, has imposed disproportionate burdens on smaller entities while potentially under-regulating larger, more complex operations.

When establishing TPMO categories, CMS should consider the following critical factors that drive different risks, compliance capabilities, and regulatory needs:

Organizational Function

TPMOs engage in vastly different activities within the Medicare marketplace, including:

- Enrollment-focused entities that primarily conduct sales presentations and process enrollment applications.
- Post-enrollment service providers that focus on ongoing member support, retention activities, and service after enrollment.
- Marketing specialists that generate leads, create awareness, and conduct advertising and promotional activities.
- Full-service operations that handle the entire continuum from initial marketing through enrollment and post-enrollment support.

The scope of activities of these entities directly impacts the level of beneficiary interaction, potential for harm, and appropriate oversight requirements. An entity that only generates leads and refers prospective enrollees, for example, has fundamentally different compliance needs than an entity that conducts sales presentations, processes enrollments, and provides ongoing member services.

TPMO Proposed Categories

Taking into account these considerations, NAIFA recommends that CMS establish the following TPMO categories:

- Professional Agents: Individual agents and small agencies who provide direct, personalized enrollment assistance to beneficiaries.
- Field Marketing Organizations (FMOs): Organizations of various sizes that act as intermediaries between insurance carriers and independent agents to provide essential support, including contracting, sales training, compliance, and access to technology, allowing agents to effectively serve beneficiaries.
- High-Volume Call Centers: Organizations operating centralized telephone-based or online enrollment operations with scripted presentations.
- Lead Generation/Marketers: Organizations that identify prospective beneficiaries and market Medicare plans to individuals using any method of communication in order to generate consumer interest in such plans.

Once specific categories are established, CMS should develop requirements that are appropriately scaled to:

- Level of direct beneficiary interaction
- Organizational complexity and resources
- Risk profile for potential beneficiary harm
- Ability to implement compliance controls
- Adjust incentives to encourage consumer satisfaction and retention

Clear Guidance on FDR vs. Non-FDR Status

NAIFA urges CMS to provide explicit guidance on when a TPMO must be classified as an FDR and when it may operate as a non-FDR service provider. This clarity is essential for:

- Plans to properly structure their downstream relationships
- TPMOs to understand their compliance obligations
- CMS to conduct appropriate oversight of MAOs

The current ambiguity creates uncertainty and potential gaps in oversight.

Preserve Agent Independence and Address Compensation Transparency

Any modified TPMO definition should preserve the ability of all agents to serve beneficiaries effectively while ensuring required transparency in all areas to beneficiaries.

With agents, a consumer has:

- Personalized guidance from a licensed individual who is able to give advice (which is not allowed unless a person maintains an insurance license).
- Choices across multiple carriers and plan options.
- Service in underserved markets where other resources are unavailable.
- Long-term relationships with agents to assist with ongoing beneficiary needs.

Overly broad TPMO requirements that fail to differentiate between the above entity types could inadvertently reduce beneficiary access to professional advice, depending on the nature of the regulations.

Benefits of Differentiated TPMO Classifications

Modifying the TPMO definition to delineate different roles and requirements based on organizational function, business models, and financial transactions would:

- Improve Beneficiary Protection: Targeted requirements based on actual risk, communication method(s), and function will be more effective than 'one-size-fits-all' regulations. Higher-risk entities would receive appropriately enhanced oversight from MAOs.
- Enhance Regulatory Efficiency: CMS and plans can focus oversight resources where they are most needed.
- Reduce Unnecessary Burden: Smaller entities will not face disproportionate requirements designed for complex and multi-layered organizations.
- Increase Transparency: Clear categories and compensation disclosure requirements enable all parties—beneficiaries, agents, plans, and CMS—to understand the incentive structures at play.
- Increase Compliance: Clear, appropriate requirements tailored to specific business models are more likely to be followed and easier to enforce. Identifying and registering lead generation/marketers will lead to better transparency to CMS, MAOs, and agents as to the origin of marketing collateral and consumer interactions.
- Address Root Causes of Misconduct: The differentiated approach targets the financial incentives that drive inappropriate practices rather than simply adding procedural requirements.
- Promote Market Competition: A well-functioning and well-defined ecosystem with appropriate differentiation supports beneficiary choice while preventing race-to-the-bottom dynamics driven by opaque compensation arrangements.

Conclusion on TPMO Definition

NAIFA commends CMS for recognizing the need to differentiate among TPMOs and strongly supports this regulatory initiative. This differentiated approach will strengthen beneficiary protections where they are most needed, reduce unnecessary burden on lower-risk entities, and address the risks and structures that create opportunities for misconduct.

NAIFA urges CMS to engage in further dialogue with stakeholders as it develops specific regulatory language and to consider the framework outlined above. NAIFA and our members stand ready to provide additional input and expertise to assist CMS in developing an effective, workable approach to TPMO classification and regulation that protects beneficiaries while supporting a healthy, competitive Medicare marketplace.

II. Scope of Appointment: Timing of Personal Marketing Appointment After SOA Form Completion

NAIFA supports CMS's proposed changes regarding the timing of personal marketing appointments after the Scope of Appointment (SOA) form completion. We appreciate CMS's ongoing efforts to balance beneficiary protection with practical implementation considerations for agents and plans. The proposed modifications represent thoughtful evolution of the SOA requirements and will help streamline the appointment process while maintaining appropriate safeguards.

Areas of Agreement

NAIFA supports the following aspects of the proposed changes:

- Clarification of timing requirements that provide greater certainty for agents and beneficiaries.
- Recognition of practical challenges in scheduling and conducting appointments under the current 48-hour framework.

These provisions strike an appropriate balance between protecting beneficiaries from high-pressure sales tactics and allowing legitimate marketing activities to proceed efficiently.

Proposed Modifications

While NAIFA supports the overall direction of the proposed SOA changes, we have concerns about four specific aspects of CMS's proposal that we believe require modification to ensure the policy achieves its intended objectives. These modifications will strengthen beneficiary protections, prevent potential abuse, reduce unnecessary administrative burden, and align SOA requirements with modern business practices and consumer expectations.

Interpretation of "In Writing" to Exclude Electronic Means

CMS's Position:
CMS interprets the statutory requirement that SOA forms be obtained "in writing" to exclude electronic means of collecting SOA consent.

NAIFA's Concern:
This interpretation is fundamentally inconsistent with modern business practices, consumer expectations, and the direction of federal policy on electronic signatures and records. The interpretation creates unnecessary barriers to efficient service delivery while providing no additional protection to beneficiaries.

Today's Medicare beneficiaries—including those turning 65—are increasingly comfortable with and prefer electronic communication.

- Email and text messaging are primary communication channels for many beneficiaries.
- Electronic forms can be completed on a beneficiary's own time, without pressure.
- Digital records are easier for beneficiaries to retain and reference.
- Electronic collection enables immediate confirmation and documentation.

Requiring paper-only SOA forms actually reduces accessibility for beneficiaries who prefer digital communications and may create barriers for beneficiaries with mobility limitations, those in rural areas with limited mail service, or those who prefer not to have in-person meetings.

NAIFA's Recommendation:
We propose that CMS adopt a modern definition of "in writing" that explicitly includes electronic means of collecting the SOA.

Product Type Specificity Limited to Particular Plan Year

CMS's Position:
As stated on page 207 of the proposed rule, CMS interprets that the product type specified on an SOA form is specific to a particular plan year.

NAIFA's Concern:
This interpretation significantly undermines the utility of the 12-month validity period for SOA forms and creates confusion for both beneficiaries and agents. It requires beneficiaries to complete new SOA forms even when discussing the same product types, simply because a new plan year has begun.

Many beneficiaries work with the same agent year after year. Requiring new SOAs each plan year disrupts the continuity of this relationship and suggests that the agent's authorization to discuss products expires simply because the calendar changed, even though:

- The beneficiary's consent to discuss those product types has not changed.
- The agent-beneficiary relationship has not changed.
- The types of products being discussed have not changed.

NAIFA's Recommendation:
We propose that the SOA form remains valid for the full 12-month period from the date of signature for the specified product types, regardless of plan year transitions.

Limited Beneficiary Control Over SOA Duration

CMS's Position:
The proposed rule establishes a fixed 12-month validity period for SOA forms without providing beneficiaries the option to extend this authorization.

NAIFA's Concern:
This approach does not empower Medicare beneficiaries to make their own informed choices about how long they wish to authorize an agent to discuss plan options with them.

Medicare beneficiaries are capable of making informed decisions about their healthcare and the assistance they want in navigating plan options. Many beneficiaries:

- Develop long-term relationships with trusted agents.
- Prefer not to complete paperwork repeatedly for ongoing relationships.
- Understand that they can end the relationship at any time.

NAIFA's Recommendation:
We propose empowering the Medicare beneficiary with the option to allow the SOA to be valid until they choose to rescind permission. This approach would respect beneficiary autonomy while also providing appropriate safeguards to prevent abuse.

Insufficient Minimum Requirements for SOA Forms

CMS's Position:
CMS proposes that the only "minimum requirement" for SOA documentation is the product type to be discussed.

NAIFA's Concerns:
This minimal approach creates several potential problems, including:

1. Opens the Door to SOA Sharing Between Agents

If the only required information is "product type," an SOA form could theoretically be used by any agent to contact a beneficiary:

- Agent A obtains an SOA listing "Medicare Advantage" as the product type.
- Agent B could use that same SOA to contact the beneficiary, claiming authorization.
- The beneficiary has no idea which agent is authorized to contact them, potentially creating an unnecessary level of confusion.

2. Prevents Meaningful Verification

Without basic identifying information, neither beneficiaries, agents, nor plans can:

- Verify which specific agent is authorized to contact the beneficiary.
- Confirm when the authorization was granted.
- Determine whether the authorization is still valid.
- Maintain proper documentation for compliance purposes.

NAIFA proposes that SOA forms must include, at a minimum:

- Beneficiary Name - To clearly identify the individual providing consent.
- Agent/Agency Name - To specify who is authorized to conduct the appointment and prevent sharing of SOAs between agents.
- Product Types to be Discussed - To define the scope of the appointment (MA, PDP, Cost Plans, etc.).
- Date of Signature - To establish the beginning of the 12-month validity period and allow verification of currency.

These four elements are essential to ensure:

- Accountability: Clear identification of which agent has permission
- Verification: Ability to confirm authorization is current and valid
- Prevention of Abuse: Cannot be transferred or shared among agents
- Beneficiary Understanding: Clear record of what was authorized and when

Conclusion on Scope of Appointment

NAIFA appreciates CMS's ongoing refinement of the Scope of Appointment requirements and supports the general direction of the proposed changes. However, we ask CMS to reconsider the concerns outlined above to ensure the proposed policy achieves its intended purpose of protecting beneficiaries while maintaining an efficient, accessible Medicare marketplace.

NAIFA looks forward to working with CMS to refine these provisions and stands ready to provide additional technical assistance or expertise as needed.

III. Third-Party Marketing Organization (TPMO) Oversight: Call Recording Retention Requirement

NAIFA strongly applauds CMS's recognition that the current 10-year retention period for marketing and sales call recordings is overly burdensome and unnecessary. This proposed modification represents a thoughtful recalibration of regulatory requirements that maintains beneficiary protection while eliminating wasteful compliance costs that provide minimal value.

NAIFA believes that CMS should continue to require call recording and recognizes the significant value this requirement provides to Medicare beneficiaries, including

- Accountability: Creates an objective record of what was actually said during marketing and sales interactions.
- Dispute Resolution: Provides definitive evidence when beneficiaries raise concerns about misrepresentation or unauthorized enrollment.
- Quality Assurance: Enables plans and regulators to monitor compliance with marketing rules.
- Training and Improvement: Allows identification of problematic practices and improvement of agent performance.
- Deterrence: The knowledge that calls are recorded encourages agents to follow rules and treat beneficiaries appropriately.

These benefits are real and substantial. NAIFA supports the continuation of call recording requirements as an important consumer protection tool in the Medicare marketplace. However, we strongly support the CMS determination that the current 10-year retention requirement is

unnecessary for ensuring appropriate safeguards and protections for Medicare beneficiaries. Among the burdensome consequences of the 10-year retention requirement are the following:

Significant Storage Costs

Retaining call recordings for 10 years creates enormous data storage requirements, including:

- Audio files for hundreds or thousands of calls per agent annually
- Requirement for secure, compliant storage systems
- Exponential growth in storage needs as programs mature
- Costs that ultimately may be passed on to beneficiaries through higher premiums or administrative fees

Technology Infrastructure Costs

Maintaining recordings for 10 years requires:

- Enterprise-grade storage systems with redundancy
- Cybersecurity protections for sensitive beneficiary information
- Regular technology upgrades and migrations as systems evolve
- Disaster recovery and backup capabilities
- Compliance with data security standards
- Many smaller agencies and independent agents struggle to afford or maintain this level of infrastructure for what amounts to historical data with minimal practical utility

Retrieval and Management Burden

Even when recordings exist, retrieving and reviewing 10-year-old recordings presents challenges:

- Indexing and cataloging thousands of files
- Time required to locate and review specific calls
- Potential incompatibility with current playback systems

Privacy and Security Risks

Longer retention periods increase privacy and security risks:

- More data creates more targets for cybersecurity breaches
- Sensitive beneficiary information (health conditions, financial information) retained unnecessarily

- Increased risk of unauthorized access over extended timeframes
- Compliance challenges with evolving privacy regulations across multiple jurisdictions

Minimal Utility After Initial Period

The practical reality is that nearly all complaints, disputes, and compliance issues are identified within the first few years after a marketing interaction:

- Beneficiaries discover problems when they attempt to use coverage or receive unexpected bills
- Enrollment discrepancies are typically identified within the first plan year
- Misrepresentation claims arise when beneficiaries realize coverage differs from what was promised
- CMS compliance reviews and audits focus on recent activity, not decade-old marketing calls

By the time a recording is five years old, its practical utility for any stakeholder—beneficiary, plan, regulator, or agent—is very low.

NAIFA's Recommendation

NAIFA believes that a three-year record retention period for all call recordings is sufficient time to uncover any Medicare beneficiary complaints and represents the appropriate balance between beneficiary protection and regulatory efficiency.

A three-year retention requirement is appropriate because:

- Captures the relevant complaint window: Complaints arising more than three years after a call are rare and typically involve issues that could be evident from other documentation rather than requiring call recordings.
- Aligns with CMS audit practices: As CMS acknowledges, program audits and compliance reviews typically focus on more recent activity. It is far more likely, for example, that compliance audits and investigations will review current or prior-year activities instead of longer-term trends. If CMS oversight activities do not routinely require recordings older than 3 years, there is no justification for requiring TPMOs and plans to retain them for 10 years.
- Aligns with Medicare program cycles: Beneficiaries have the option to change planes during each annual enrollment period, meaning enrollees will likely switch plans every one

or two years if they are experiencing significant problems. As a result, three years provides sufficient time for data patterns and trend analysis.

- Reduces costs without compromising protection: As CMS acknowledges, a three-year retention requirement would significantly reduce storage costs and simplify data management processes and retrievals. This would lead to lower cybersecurity risks by reducing the amount of sensitive data retained and decreased associated technology infrastructure requirements, which would be particularly beneficial to smaller entities that have fewer resources at their disposal.

Transcript Alternative

CMS has proposed that plans and TPMOs could maintain transcripts of call recordings beyond the initial retention period. Although this may represent a compromise, NAIFA does not believe there is value in maintaining any record (call records or transcripts) after three years, as it offers very little value to enhance compliance and oversight. NAIFA is not aware of any scenario where a call transcript from, say, five or seven years ago would be necessary or useful.

Implementation Considerations

If CMS adopts a three-year retention period, NAIFA recommends an immediate application, which would allow entities to immediately dispose of recordings older than three years measured from the date of the call. Additionally, NAIFA recommends that CMS include an appropriate safe harbor provision whereby entities that dispose of recordings in accordance with the law will not be penalized if recordings are subsequently requested but no longer exist.

Conclusion on Call Recording Requirements

NAIFA commends CMS for recognizing that the 10-year retention requirement is overly burdensome and for proposing to reduce this requirement. This demonstrates CMS's commitment to evidence-based regulation and elimination of unnecessary compliance costs. However, NAIFA urges CMS to go further and adopt a 3-year retention period for marketing and sales call recordings, with no requirement for maintaining transcripts beyond this period.

This approach would maintain all practical beneficiary protections, eliminate substantial regulatory waste and cost, align with CMS oversight practices, reduce cybersecurity and privacy risks, and support consistent compliance among TPMOs of all sizes.

NAIFA thanks CMS for considering this issue thoughtfully and stands ready to provide additional data, analysis, or technical assistance to support adoption of a three-year retention standard.

IV. Special Enrollment Period for Provider Terminations

NAIFA strongly supports the proposal to streamline the Special Enrollment Period (SEP) for beneficiaries affected by provider terminations from Medicare Advantage plan networks. The proposal represents a thoughtful improvement to an existing beneficiary protection that will reduce delays, eliminate unnecessary administrative steps, and ensure more beneficiaries are promptly informed of their rights.

Under current requirements:

- CMS must first determine that a provider network change is deemed significant.
- The determination involves an internal CMS review process that evaluates the totality of the circumstances.
- MA organizations must notify CMS of no-cause provider terminations at least 90 days in advance.
- The timeframe for CMS determinations varies on a case-by-case basis.
- Only after CMS decides a significant change has occurred are affected enrollees notified of SEP eligibility.
- This creates a separate notification process distinct from routine provider termination notices.

Enrollees are considered affected by a significant network change when they are assigned to a terminated provider or facility, currently receiving care from a terminated provider or facility, or have received care within the past three months from a terminated provider or facility.

The current system, as CMS acknowledges, creates several issues that lead to inefficiencies and potentially deprives beneficiaries of receiving prompt notification of their rights and enrollment options. Among the concerns are:

- Beneficiaries must wait for CMS to complete its significance determination before being notified of SEP eligibility, even though they've already been notified of the provider termination.

- MA organizations must send one notice about the provider termination and then, if CMS determines significance, an additional notice about SEP eligibility.
- Whether beneficiaries receive SEP notification depends on CMS's determination of "significance," leading to uncertainty and confusion for the beneficiary.
- CMS data shows that in 2024, only approximately 3.6% of eligible enrollees actually utilized the SEP, suggesting the current process may not effectively reach beneficiaries who need it.

We applaud CMS for proposing to consolidate the notification process by requiring MA organizations to include SEP eligibility information in the provider termination notice itself, which will eliminate the need for a separate SEP notice after CMS makes a determination of significant changes and ensure that affected enrollees receive timely, comprehensive information.

The proposed process will give beneficiaries faster access to SEP rights, create a more consistent approach, lead to greater administrative efficiency, and empower beneficiaries to use an SEP when it serves their healthcare needs, all while maintaining important beneficiary protections.

NAIFA's Recommendation

While NAIFA supports CMS's proposed streamlining of the provider termination SEP, we would be in favor of CMS also allowing proof of the termination letter as evidence for an SEP. This will provide an added safeguard to prevent the SEP from being abused as a “get out of plan free” path, which has been a concern in the past. SEPs are often abused and have been used inappropriately as the DSNP SEP was altered last year.

CMS proposes that "MA organizations would be able to determine eligibility for the proposed SEP for Provider Terminations based on beneficiary attestations of election period eligibility." While attestation-based systems offer simplicity, requiring documentation of the provider termination notice would provide important additional safeguards without creating significant burden.

Conclusion on SEPs for Provider Terminations

NAIFA supports CMS's proposal to streamline the Special Enrollment Period for provider terminations. These changes will benefit Medicare beneficiaries by providing faster access to their enrollment rights and more consistent application of the SEP.

V. Marketing Events Following Educational Events in the Same Location

NAIFA strongly supports CMS's proposal to modify the restriction on conducting marketing events at the same location within 12 hours of an educational event. This is a commonsense regulatory improvement that eliminates an unnecessary burden on agents, which provides little to no benefit to beneficiaries. In fact, current regulations can actually hinder beneficiary access to professionalized guidance on choosing the plans that best meet their healthcare needs.

Under current regulations, plans and their representatives are prohibited from conducting a marketing event at the same physical location within 12 hours of an educational event. This restriction was implemented to prevent beneficiaries from being confused about the nature of events and to protect them from high-pressure sales tactics immediately following educational sessions.

While the intent is laudable, the 12-hour restriction creates significant practical problems for beneficiary convenience and access to professional guidance. Many beneficiaries prefer to attend both educational and marketing events on the same day, particularly those with limited transportation options or mobility challenges that can make traveling difficult; anyone living in rural or underserved areas; and beneficiaries who want to make immediate decisions about their healthcare. The current 12-hour rule forces beneficiaries to make multiple trips to the same location on different days, creating unnecessary inconvenience and potentially reducing access to information and products.

CMS's proposed approach is the appropriate balance to the problems identified above as it:

- Maintains core beneficiary protections: Education events will still need to comply with existing law and remain purely educational in nature, with proper notification given to beneficiaries when an educational event concludes and a marketing event begins.
- Respects beneficiary choice: Beneficiaries who want to attend both an educational session and a marketing event on the same day should have that option. Many beneficiaries are sophisticated consumers capable of distinguishing between education and marketing, eager to gather information and make timely decisions that fit with their schedules.
- Improves access and efficiency: Eliminating the current restriction enables more efficient use of community venues and resources, allows agents to serve more beneficiaries in a

timely manner, and reduces the overall costs associated with educating consumers on the health plan options available to them.

Conclusion on Marketing and Educational Events

NAIFA commends CMS's proposal to modify the 12-hour restriction on marketing events following educational events at the same location. The proposed change represents thoughtful deregulation that removes unnecessary obstacles and maintains appropriate guardrails to protect beneficiaries.

VI. Conclusion

NAIFA appreciates CMS's commitment to improving the Medicare Advantage and Part D programs through the thoughtful proposals in this rule. The proposed changes reflect a genuine effort to balance beneficiary protection, regulatory efficiency, and marketplace functionality.

NAIFA respectfully requests the opportunity for continued dialogue with CMS as these proposals are refined and finalized. Our members' day-to-day experience serving Medicare beneficiaries provides valuable insights into how regulations work in practice. We stand ready to

- Provide additional data or analysis on any of the topics addressed in this letter.
- Participate in stakeholder meetings or working groups.
- Assist with development of model language or implementation guidance.
- Share best practices from our members' experience.

Thank you for considering NAIFA's comments on this important proposed rule. We appreciate CMS's ongoing efforts to improve the Medicare program and look forward to working collaboratively to ensure these regulations effectively protect beneficiaries while supporting a robust, competitive marketplace.

Sincerely,

Christopher L. Gandy, LACP
2026 NAIFA President